Today's Date: _____
Date Due: _____
(10 days)

EMPLOYER INSURANCE VERIFICATION

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE
HIPP Program (Health Insurance Premium Payment)
600 E. Broad Street, Suite 1300
Richmond, VA 23219
(804) 225-4236 (800) 432-5924 (in Virginia only)

The State of Virginia is considering paying the health insurance premium on behalf of the employee listed below, in accordance with Section 1906 of the Social Security Act. Any information provided on this form will remain confidential. In order to help us make a determination, please return this form within 10 days. A pre-addressed stamped envelope is enclosed for your convenience.

PART A – ELIGIBILITY

1. Employee Status ☐ full time ☐ part-time
2. Is this employee eligible for coverage under your company's group health plan? ☐ yes ☐ no
   (if "no", reason: _____)
   (if "no", fill out PART E only and return)

PART B – MEMBERSHIP

Employee	SS#	Birthdate	Eligibile for health plan ☐ yes ☐ no Currently enrolled in health plan ☐ yes ☐ no

Dependents	SS#	Birthdate	Relationship	Eligible for health plan	Currently enrolled in plan
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no

PART C – COVERAGE

1. If the employee is currently enrolled, what is the type of coverage?

   ☐ **Employee Only** ☐ **Employee Plus Child** ☐ **Family**

   Effective Date_____

2. If the employee is not currently enrolled, when can enrollment occur?

☐ Open Enrollment Dates: From_____ To_____
☐ Other_____
☐ **Signature of Applicant**_____ **Please be advised this signature serves as a release of information document for verification of all required information.**

PART D – PLAN BENEFITS

Please indicate cost and benefits for the coverage the employee has elected.

Name and Address of Insurance Company

_____
_____
_____
_____
Phone Number_____

Premium Information
(employee's portion only)

Coverage	Premium Amount	How Often
Employee Only	$_____	☐ Weekly
Employee + Child	$_____	☐ Every Two Weeks
Family	$_____	[ ] 24/year
		[ ] 26/year
		☐ Monthly

Type of Plan:

☐ Hospital Only
☐ Comprehensive Major Medical
☐ PPO
☐ HMO
☐ Other (please explain)_____
_____

Services Covered:

☐ Medical
☐ Drugs
☐ Dental

Name and Address of Insurance Company

_____
_____
_____
_____
Phone Number_____

Premium Information
(employee's portion only)

Coverage	Premium Amount	How Often
Employee Only	$_____	☐ Weekly
Employee + Child	$_____	☐ Every Two Weeks
Family	$_____	[ ] 24/year
		[ ] 26/year
		☐ Monthly

Type of Plan:

☐ Hospital Only
☐ Comprehensive Major Medical
☐ PPO
☐ HMO
☐ Other (please explain)_____
_____

Services Covered:

☐ Medical
☐ Drugs
☐ Dental

Please note: State regulations require that the information requested on this form must be be verified by telephone before acceptance into the HIPP Program can be finalized.

PART E – EMPLOYER'S REPRESENTATIVE:

I hereby certify that all information contained herein is true and is correct to the best of my knowledge.

Group Administrator for Health Insurance Plan_____
Employer_____
Employer's Address_____
Department_____
Phone Number_____

Signature_____ Date _____